Issue Date: February 3, 2003
Closing Date: February 24, 2003
Closing Time: 12:00 EST

SUBJECT: Draft Program Description for "Monitoring and Evaluation to Assess And Use Results" (MEASURE Phase II) Cooperative Agreement

Ladies/Gentlemen:

THIS IS NOT A REQUEST FOR APPLICATION. USAID is preparing for issuance of a Request for Application (RFA) for the subject program. USAID is soliciting comments from interested parties, in order to further refine this Draft Program Description (DPD). This procurement will be a full and open competition. Your comments will be appreciated and considered as we finalize the solicitation for applications. No information on pricing is available at this time.

USAID anticipates that this award will be a Cooperative Agreement. The targeted date for this award is o/a July 2003.

Answers to questions will be posted in the solicitation (applicants will not be identified with the question). Comments may or may not be incorporated in the Program description. Comments will be accepted until February 24, 2003, 12:00 EST. All comments shall be addressed to Eduardo G. Elia in writing (e-mail preferred: eelia@usaid.gov), fax: (202) 216-3132, or by mail addressed: USAID, 1300 Pennsylvania Ave., Attn: Eduardo Elia, M/OP/G/PHN, RRB 7.9.133, Washington, DC 20523.

Thank you for your interest.

Sincerely,

Eduardo G. Elia
USAID
Office of Procurement
M/OP/G/PHN

SECTION V

PROGRAM DESCRIPTION

Note: The following background discussion is relevant not only to the activity anticipated by this RFA, but to all the MEASURE Phase II activities discussed below. The Program Description for this award follows the BACKGROUND section.

PART I. BACKGROUND

I. Introduction

The U.S. Agency for International Development's (USAID) Bureau for Global Health (GH) intends to continue supporting the 11-year activity entitled "Monitoring and Evaluation to Assess and Use Results" (MEASURE). The MEASURE Activity (previously known as the MEASURE Results Package) began in 1997 and will continue until 2008. Planned for implementation in two phases, the MEASURE Activity is at a key juncture – implementation of MEASURE Phase II. This background section describes the experience leading up to MEASURE Phase II, presents the Guiding Principles and MEASURE Phase II Results Framework, discusses activity implementation and describes the component projects of MEASURE Phase II. The award for the MEASURE Phase II cooperative agreement described in the Program Description following this background section is part of MEASURE Phase II.

Phase II of the MEASURE Activity is part of the GH strategic framework and is supportive of the strategic objectives of the Agency. MEASURE Phase II will continue to support all of the GH Strategic Objectives (SO) by addressing the following technical areas: family planning, reproductive health, maternal health, child survival, nutrition, and infectious diseases, primarily tuberculosis, malaria, and STD/HIV/AIDS. Throughout this document the term health is used to encompass all of these technical areas unless otherwise specified.

MEASURE Phase II has been developed on the premise that *generating demand for* and *improving the use of* data in policy formulation, program planning, monitoring and evaluation improves health services and consequently, health outcomes. The focus will be on:

- identifying potential data users and increasing their demand for health data;
- working with data users to build a demand for information and to define the essential health data to collect;
- determining the most appropriate data collection approaches, routine and non-routine, to use;
- developing innovative approaches for collecting better data including those using new technologies and lower-cost methodologies;
- translating data into information that informs program planning and policymaking;

- packaging data in forms that best meet users' needs;
- disseminating information and improving its use in influencing policy and improving program planning;
- facilitating use of data by ensuring that data users are included in the data collection, analysis and dissemination process; and
- building the capacity of data users and producers in all of these areas.

II. Overview

USAID has long recognized that the timely collection, analysis and use of reliable demographic and health data are crucial for planning, monitoring, and evaluating health programs. Over the past three decades, USAID has sponsored a range of data collection activities from large stand-alone national survey programs, such as the DHS Program, to limited collection of data for impact studies within GH or mission bilateral projects. Data collected have included population-based data gathered through censuses and demographic and health surveys; facility-based data; data to monitor program performance or test interventions through operations research and special studies; surveillance data to monitor disease prevalence; and routine health systems data to monitor and better understand health service utilization, provision, and cost.

USAID also recognized that data collection alone is not sufficient. In the early 1990s it developed the EVALUATION Project to improve methodologies for monitoring and evaluating its population programs. The EVALUATION Project disseminated the best monitoring and evaluation (M&E) practices and initiated activities to build capacity to monitor and evaluate programs. In addition, USAID developed several projects dedicated to data dissemination and improving the use of data in policy-making and program planning. USAID also realized that there were many synergies among the activities of these separate projects and that their impact could be strengthened by combining them under a single results package.

In 1996 USAID's Center for Population Health and Nutrition (PHN Center), developed the MEASURE Results Package. In this document, the MEASURE Results Package, implemented from 1997-2003, is referred to as MEASURE Phase I. MEASURE Phase I was designed to be a collaborative partnership that brought together efforts to improve data quality and data collection methodologies; data collection; data analysis; data dissemination and use activities; as well as efforts to build capacity in all of these areas. MEASURE Phase I was also designed to address all of the PHN Center SOs in order to better meet the needs of integrated health programs and be more responsive to data users.

The Strategic Objective of MEASURE Phase I is: to improve and institutionalize the collection and utilization of data for monitoring and evaluation of host-country programs and for policy decisions. This objective is to be accomplished by achieving five results:

1) improved coordination/partnerships at international, USAID, cooperating agency (CA), and country levels;
2) increased host country institutionalization;

3) improved tools and methodologies to achieve increased technical relevance and usefulness of data collection and analysis for specific customer and program needs;
4) improved information through appropriate data collection, analysis and evaluation; and
5) improved dissemination and utilization of data.

The components of MEASURE Phase I include: MEASURE DHS+, MEASURE Evaluation, MEASURE Communication, and Participating Agency Service Agreements (PASAs) with the Bureau of Census (Survey and Census Information, Leadership, and Self-Sufficiency [BUCEN-SCILS]) and with the Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention (CDC/DHR). MEASURE Communication, with its focus on data dissemination and information communication, is the one component of the results package that was completely new at the time of the design. It was designed as a separate component to place greater emphasis on this function.

MEASURE Phase I has advanced the state of the art and provided technical leadership in data collection, monitoring, evaluation, dissemination, and capacity building in these areas. In addition to MEASURE Phase I, USAID supports data collection and evaluation activities within GH flagship projects and mission bilateral projects. When appropriate and feasible, MEASURE Phase I has collaborated and worked in partnership with these efforts. In addition, MEASURE Phase I partners have provided direct technical support and training to other GH CAs as well as to implementing partners within bilateral programs.

The original intent was to implement the MEASURE Activity in two five-year phases: Phase I from 1997-2002 and Phase II from 2002-2007. However, because of the reorganization of USAID during 2001-02, the newly-reorganized GH Bureau decided to invest more time in the design of MEASURE Phase II in an effort to ensure that it would best meet the needs of the field and the reorganized Bureau. Due to the lengthened design process, Phase I has been extended through December 2003, and Phase II is now planned for 2003-2008.

The concept for MEASURE Phase II was developed through a participatory design process that included representatives of each of the five SO teams within the GH Bureau, and input from USAID Missions and regional bureaus. The design process also benefited from the results of the "Evaluation and Pre-design Study" conducted by the POPTECH Project in June 2001.[1]

III. Focus of MEASURE Phase II

MEASURE Phase II will be focused on and framed around a continuum of data demand generation, collection and use activities including: the ***generation of demand*** for quality data; the ***process*** of data collection and analysis; and the ***use*** of data for monitoring and

[1] Add citation.

evaluating programs and influencing policies. This continuum is cyclical, reflecting an iterative process. It requires that data users both demand quality data and ensure that data producers understand their priorities and information needs. It also requires data producers to work closely with data users throughout the data collection process to understand their data needs, to improve the quality of the data, to translate and package the data appropriately, and to facilitate data use.

MEASURE Phase II will play multiple roles in this data demand generation–collection–use continuum. Like MEASURE Phase I, MEASURE Phase II's activities will focus on the information collection, analysis and dissemination portion of the continuum. This involves: developing appropriate methodologies and instruments for collecting health and demographic data; collecting and analyzing data; translating data into information that informs decision-making; packaging and disseminating information in forms that meet users' needs; and building capacity of data users and producers in all of these areas. MEASURE Phase has been recognized worldwide for the technical expertise of its staff and for its ability to produce reliable and credible standardized data that can be used for cross-country comparisons at the global level, for tracking trends at the national and sub-national levels and for monitoring and evaluating programs. MEASURE Phase II will also continue MEASURE Phase I's role of serving as a technical resource and providing guidance to USAID missions, host-country partners and CAs as they develop comprehensive, national data collection plans and collect sub-national or project-specific data, including routine data. Finally, MEASURE Phase II will continue MEASURE Phase I's key role in the collection of national-level household and facility-based data. In this effort, data will be collected for a core set of variables and modules will be used to collect data on particular issues to meet country-specific data needs.

Two new areas of emphasis for MEASURE Phase II that go beyond the work of MEASURE Phase I will be *generating demand* for data and *facilitating use* of data. MEASURE Phase II will work with data users to help them develop an appreciation of the power of evidence-based management and policymaking. Data users include staff at the national and sub-national levels of ministries, advocacy groups, media organizations, NGOs, private sector organizations, USAID and other bilateral and multilateral donor agencies and CAs. These users encompass a wide range of individuals with varied data needs and levels of technical proficiency. MEASURE Phase II will first help identify the data users in a country and assist them to define their specific data needs. It will then provide technical assistance as needed in the collection of data and will facilitate data use by translating it into useful information that is packaged in the appropriate formats and media that can be used and applied to improve decision-making.

MEASURE Phase II's role in generating demand for data and facilitating its use will vary depending upon the country situation. In some countries it will play a lead role; in others it will develop close links with other CAs; and in others, host country agencies will take the lead to ensure that data are used to improve policies and programs. This will require MEASURE Phase II to work closely with a wide variety of host-country partners, GH CAs, missions, and SO teams to ensure that the data collected *are those needed* to improve programs and policies. MEASURE Phase II will also work with these partners

to facilitate their *use* of the data to improve policies and programs. MEASURE Phase II will need to build strong links with other GH CAs, including POLICY II, PHR Plus, MNH, FRONTIERS, BASICS II, MLD, QAP, the Health Communications Partnership, EHPII, PHNI, INFO, CHANGE, SYNERGY, IMPACT and TEPHINET, to generate demand for data and facilitate its use.

1. Gender Perspective in Phase II

In order for MEASURE Phase II to collect data that effectively improves health programs, data collection efforts, analysis methodologies, and plans for data use must further our understanding of how culturally-defined norms and values associated with being male or female influence health decision-making, practices and healthcare-seeking behavior. MEASURE Phase II will take gender into account during the design and implementation of activities along the whole data demand generation-collection-use continuum. It will collect sex-disaggregated data, conduct special analyses, and present information that increases understanding of gender norms in a particular country or regional context. It will also ensure that data collection approaches are reliable and representative for men and women. In addition, it will develop methodologies and indicators that monitor progress in incorporating these findings into programs. Finally, MEASURE Phase II will take particular care to select trainees and staff for its activities with the goal of building local capacity of both men and women to articulate data needs and to demand and use data to better understand gender norms and their influence on health-seeking behavior. Specific efforts will be made to involve women in the decision-making process.

Particular effort will be made to package information and data in ways that maximize their use in discussions of inequities among women and men in terms of health status and use of healthcare services. Gender-relevant data will be translated and disseminated to a wide range of users including non-technical audiences such as women's advocacy groups, the media, and policymakers in order to raise public awareness of the links between gender and health and to influence the policy process.

2. Guiding and Design Principles for MEASURE Phase II

The following guiding principles for MEASURE Phase II articulate ways of conducting business that will be critical for MEASURE Phase II's success and against which success will be evaluated. They provide a frame of reference that will be used as MEASURE Phase II moves from design through implementation to determine if proposed activities will achieve intended results.

1. Respect that the ultimate purpose of collecting data is their <u>use</u> in policy formulation, program planning, monitoring and evaluation.

MEASURE Phase II partners must recognize that there is a wide variety of data users with whom they must work closely to ensure that the data collected and information generated will indeed be used to improve health services and influence policies. The

process entails first working with data users to identify the essential health information they need. Data users include private- and public-sector providers of health care services and health care products; host country policymakers and program managers at the national, provincial and district levels; media and advocacy groups; USAID/W and USAID missions; other bilateral and multilateral donors; and CAs. Each of these user groups may have different data priorities. Thus MEASURE Phase II must work with all of them to develop a strategy that identifies the most appropriate data to collect and the most appropriate methodology for collecting them.

MEASURE Phase II partners must also work closely with data users in tracking the use of data and determining if future changes in the data collection process need to be made in order to maximize the utility of the data. MEASURE Phase II partners must coordinate with other appropriate GH CAs and missions to ensure that the data collected can and will be used to improve program implementation, policies affecting delivery of health services, and ultimately, health outcomes.

2. Foster and reinforce host-country ownership of collection, analysis, presentation and use of data.

Experience has shown that ownership evolves from participation in decision-making concerning how data will be collected, analyzed, packaged, presented and used. MEASURE Phase II must work with host-country partners at the initial planning stages to identify the information they want to collect. It must then involve data users in the data collection process to develop methodologies and instruments that are appropriate for the context and that collect reliable and valid data. MEASURE Phase II partners must strive to develop the most affordable and sustainable approaches for collecting the data that meet users' needs. After the data have been collected, MEASURE Phase II must work with data users to develop their capacity to analyze the data. Finally, it must train host-country partners to develop strategies to collect, analyze, disseminate, package and present the data in appropriate formats and media for use in policy formulation, program planning, management, monitoring and evaluation.

3. Partner strategically with key stakeholders

These include groups as diverse as national statistical offices, private- and public-sector providers of health care and health care products, host-country policymakers and program managers at national and sub-national levels and in various line ministries, multilateral and bilateral donor agencies, media and advocacy groups and other GH CAs. Frequently, these groups develop parallel data collection systems or fail to coordinate data collection efforts, thereby overwhelming the capacity of host-country data collection personnel and institutions and wasting scarce resources. To increase the effectiveness and efficiency of data collection efforts and to encourage data use, MEASURE Phase II must strategically partner with these stakeholders and work with them to coordinate efforts and resources, design and implement activities, and ensure that they have timely access to the data in appropriate formats. MEASURE Phase II must also strive to incorporate the collection of demographic and health data into ongoing country data collection efforts as much as

possible. Finally, MEASURE Phase II must build upon the efforts of MEASURE Phase I to share costs with and leverage additional funds from other donors whenever feasible.

4. Achieve best balance among AID/Washington, Mission, and host-country priorities

MEASURE Phase II will assist in collecting data to meet the needs of a variety of stakeholders. Frequently, however, these stakeholders will have different objectives resulting in an inherent tension. For example, a Ministry of Health might want to collect data to monitor a sub-national program while USAID/W might want to collect national level data. Or USAID/W might encourage MEASURE Phase II to promote more affordable data collection approaches while a mission is requesting collection of district-level data requiring a costly survey with a large sample. These competing demands are inherent in the development of data collection strategies. MEASURE Phase II must work with the various stakeholders to ensure that they understand the tradeoffs among various data collection approaches in terms of cost, quality, timeliness, level of precision, etc. In addition, MEASURE Phase II must work with these stakeholders to develop a consensus on the priority objectives for data collection, and develop a strategy that identifies the most appropriate data to collect, as well the most appropriate data collection, analysis and dissemination approaches to use.

5. Select from a variety of methods to ensure high quality data at an affordable cost

A range of data is needed for use in policy formulation, program planning, management, monitoring and evaluation. This range includes health service statistics, administrative data such as expenditures and revenues, epidemiological and surveillance data, data from client follow-up studies, vital events data, and program-level baseline and impact data. Collecting this range of data requires the use of a variety of data collection approaches and methodologies, some more costly than others. These include routine health information systems, surveys, special purpose qualitative and quantitative studies, and rapid assessments. A mix of these approaches is required because no single approach can supply all the information necessary to improve program performance or affect policy change. When determining the appropriate mix, it is essential that every effort be made to determine the most affordable and sustainable mix that collects the needed data.

MEASURE Phase II will continue MEASURE Phase I's innovative work of developing a wider repertoire of data collection tools and approaches, with an emphasis on cost-effectiveness. This repertoire will include an array of data collection techniques ranging from low-cost and rapid data collection approaches to more costly approaches that provide a greater degree of precision. It will also include modification of existing data collection efforts to include the collection of demographic and health data, as appropriate. The challenge for MEASURE Phase II will be to educate stakeholders about the costs, benefits and utility of these tools and, consequently, help them determine which tools and approaches are the most appropriate and most cost-effective to meet their specific needs.

6. Build capacity

One of the overriding objectives for MEASURE Phase II is to build capacity of host country partners to identify data needs; collect and analyze data; translate and package data for policy making and program planning; improve the use of data to make policies and plan, manage, monitor and evaluate programs. All MEASURE Phase II activities will be developed and implemented in ways that strengthen host-country ownership and build local capacity. MEASURE Phase II must take a strategic approach to develop country-specific capacity building plans that foster host-country ownership of data collection efforts; ensure coordination of training efforts of all MEASURE Phase II partners; and build sustainable institutional capacity to collect, analyze, disseminate, package and use data. Although capacity building will be aimed at both individuals and institutions, particular emphasis will be placed on strengthening host-country partner institutions in an attempt to achieve maximum sustainability of data collection, monitoring and evaluation and data dissemination and use efforts.

3. MEASURE Phase II Activity Objective and Result

The MEASURE Phase II Activity Objective (known as Strategic Objective under MEASURE Phase I) is: **Improved collection, analysis and presentation of data to promote better use of data in planning, policymaking, managing, monitoring and evaluating population, health and nutrition programs**. This Activity Objective reflects the above Guiding Principles and the new areas of emphasis of MEASURE Phase II. This Activity Objective, which replaces the MEASURE Phase I Strategic Objective, will be accomplished through the achievement of the six Results listed below (these Results replace the Intermediate Results under MEASURE Phase I). The Results as they relate to this award will be explained in detail in the scope of work of this RFP.

Result 1 **Increased user <u>demand</u> for quality information, methods, and tools.**

Result 2 **Increased in-country individual and institutional technical <u>capacity</u> and resources for the identification of data needs and the collection, analysis and communication of appropriate information to meet those needs.**

Result 3 **Increased <u>collaboration and coordination</u> in efforts to obtain and communicate health, population and nutrition data in areas of mutual interest.**

Result 4 **Improved <u>design and implementation</u> of the information gathering process including tools, methodologies and technical guidance to meet users' needs.**

Result 5 **Increased <u>availability</u> of population, health and nutrition data, analyses, methods and tools.**

Result 6 **Increased <u>facilitation</u> of use of health, population and nutrition data**

4. Implementation

A. Overview

MEASURE Phase II will operate as a GH Bureau-wide activity and will provide global assistance in the technical areas encompassed by the Bureau's three technical Offices: Health, Infectious Diseases and Nutrition (HIDN); HIV/AIDS (OHA); and Population and Reproductive Health (PRH). The MEASURE Phase II partners will work to generate demand for data, and build capacity to collect, analyze, package, present data and facilitate its use in planning, policymaking, managing, monitoring and evaluating health programs. MEASURE Phase II will consist of two competitively awarded procurements—one contract and one cooperative agreement—in addition to the PASAs with CDC and BUCEN. The four MEASURE Phase II partners will coordinate activities and collaborate in implementation in order to realize the synergies of the work they will be doing.

The MEASURE Phase II Demographic and Health Survey (DHS) Contract will build upon the work of the MEASURE Phase I DHS+ Project. One of the key objectives of this contract will be the collection of comparable, national-level survey data. However, GH expects an array of data collection approaches addressing the full range of health issues as part of the contractor's work. Additional key objectives include generation of demand for data, improved translation, packaging, and dissemination of data and development and implementation of quantitative and qualitative research. Core funding will support technical leadership; improved methodologies for population- and facility-based data collection; data archiving; innovations in data translation and dissemination, improvements in and development of tools such as the StatCompiler; and selected activities to generate demand for and facilitate use of data in policymaking and program planning. Mission funding will support the majority of in-country data collection, data analysis, dissemination, packaging and facilitation of data use activities as well as efforts to build the capacity of data users and producers in these areas.

The MEASURE Phase II cooperative agreement will build upon the efforts of the MEASURE Phase I Evaluation Project. It will focus on development of new methodologies, dissemination, capacity building and implementation of best practices in monitoring and evaluating health programs that address country-level and global M&E needs. The MEASURE Phase II cooperative agreement will provide global leadership and identify priority areas for research and development of M&E tools just as, for example, the MEASURE Phase I Evaluation Project provided leadership in the development of M&E guidelines for HIV/AIDS prevention activities. The global leadership in evaluation research, development of new methodologies and dissemination of best practices for monitoring and evaluating programs will be primarily core-funded. Mission funds will be used to provide technical assistance and training to host country counterparts as they implement the best M&E practices for monitoring and evaluating host-country and mission PHN programs. This includes technical assistance to missions developing Performance Monitoring Plans and to host-country partners developing

strategic data collection plans. The capacity building component will be both core and field-support funded. The capacity building agenda will be developed and implemented collaboratively with all MEASURE Phase II partners and, as appropriate, with other CAs.

The BUCEN PASA will build the capacity of national statistical organizations to implement censuses and other surveys. It has two main components. The first component will be primarily mission-funded and will provide technical assistance and training to strengthen institutional capacity to design and manage census and survey implementation, to analyze demographic data, and to disseminate and use census and survey data. The second component will be core-funded and will support development and on-going technical support for tools and methodologies to improve the collection and dissemination of demographic data. This includes the refinement of existing and development of new tools and computer software, such as CSPro, for use in census and survey implementation. It also includes ongoing technical support for software products, development and dissemination of training materials, and improved dissemination of demographic data.

The PASA with the Division of Reproductive Health at CDC will consist of four components. Under MEASURE Phase II, the largest component of the CDC PASA will be the provision of technical assistance in reproductive health survey design and implementation. In addition, this component will emphasize the translation and dissemination of data for use in policymaking and program planning. This component will be primarily mission-funded. The remaining components are much smaller and will be mostly core-funded. They include reproductive health epidemiology and research; epidemiological and behavioral studies that will contribute to efforts to mitigate reproductive health related morbidity and mortality of refugees and internally displaced persons; and limited technical assistance for commodity logistics management.

MEASURE Phase II will not include a separate MEASURE Communication procurement. Under MEASURE Phase I, it became clear that the administrative burden of contracting with a separate project was an obstacle that discouraged many missions from using MEASURE Communication to disseminate and communicate results. Many of the dissemination activities previously implemented by MEASURE Communication will be incorporated into the two new competed procurements and the PASAs, thus providing support for data collection, translation and dissemination within the same contracting mechanism. The four MEASURE Phase II partners will be expected to increase the availability of and facilitate the use of data collected under MEASURE Phase II. The ultimate goal of these efforts is to translate the data into relevant information that informs decisions about health services and policies and to facilitate the use of this information to promote better policymaking and program planning. In a few, selected countries, core funding may be made available to complement mission-funded activities and encourage selected country programs to implement the full MEASURE Phase II data demand generation–collection–use continuum.

The MEASURE Phase II partners must also create linkages with other GH CAs, such as POLICY II, PHR Plus, MNH, FRONTIERS, BASICS II, MLD, QAP, the Global Health

Communications Partnership, EHPII, PHNI, CHANGE, TEPHINET, SYNERGY, IMPACT and INFO, to improve the dissemination and use of data at both the global and country levels. Audiences for these activities will be diverse, ranging from journalists to district-level program managers to national-level policy makers, and activities will vary from country to country depending upon the particular needs.

B. Links to Results

USAID believes that all of the MEASURE Phase II procurements can and should significantly contribute to each of the MEASURE Phase II Results and, that only with this focus, can the "continuum" framework be successfully implemented. Thus, USAID is not assigning primary responsibility for any particular MEASURE Phase II Result to any one of the four MEASURE Phase II partners. Rather, each MEASURE Phase II partner will maximize its contribution to each of the six Results, working collaboratively with each other as well as with host-country counterparts, missions, USAID/W, regional bureaus, other CAs, and other bilateral and multilateral donors.

That being said, some MEASURE Phase II partners will contribute more to certain Results than others and each partner will have its distinct comparative advantage. The MEASURE Phase II Demographic and Health Survey contract will take the lead in implementation of national-level population- and facility-based surveys. CDC will continue to implement its reproductive health surveys and to develop innovative survey approaches for collecting data on specific issues and from special populations. BUCEN will continue to take the lead in census implementation as well as in developing innovative approaches for modifying on-going data collection efforts, such as employment surveys, to collect demographic and health data. The MEASURE Phase II cooperative agreement will take the lead in developing and implementing new monitoring and evaluation methodologies as well as in improving routine health information systems. All partners will join together to develop country-level data collection strategies to ensure that the most cost-effective and most appropriate methodologies are being used to collect the data. While each partner will disseminate the products developed in its respective area of expertise, it will also collaborate with the other partners in the development and implementation of global and in-country plans to translate, disseminate, and facilitate use of data. Finally, all partners will collaborate in the design and implementation of a strategic capacity building plan.

C. Management of MEASURE

From the USAID side, MEASURE Phase II will be managed by the USAID MEASURE team comprised of staff from the three technical offices within the Bureau for Global Health: the Office of Population and Reproductive Health; the Office of Health, Infectious Disease and Nutrition; and the Office of HIV/AIDS. Administrative and technical responsibilities for MEASURE Phase II will span GH in order to make it a "Bureau-wide Activity", promote participation from all Offices, and expand the technical expertise of the USAID MEASURE Team to be consistent with the technical areas covered by the MEASURE Phase II Activity. As in Phase I, significant attention will be

given to collaboration and coordination across Offices as well as with missions, the regional bureaus, and other parts of USAID.

The USAID MEASURE Team will provide technical direction to MEASURE Phase II. The Team will organize regular meetings with the leadership of the MEASURE Phase II implementing partners. Among the objectives for these meetings will be the joint review of workplans, field programming, and cross-cutting efforts such as demand generation, capacity building, development of new methodologies and efforts to improve data quality, data translation, data dissemination and facilitation of data use. These meetings will focus on coordination and collaboration and strengthening the MEASURE Phase II Activity as a whole. Additional working groups of technical staff may be formed as necessary to facilitate collaboration of technical work as well as country activities. The USAID MEASURE Team will also work closely with PHN mission officers and GH country coordinators to help them understand the services provided by each of the MEASURE Phase II partners and how to access the most appropriate MEASURE Phase II services.

D. MEASURE Phase II Customers and Partners

The MEASURE PHASE II Activity will serve the data collection, monitoring and evaluation needs of a number of customers. Primary customers include host-country counterparts in the public and private sectors, including media and advocacy groups; USAID missions, GH, and other technical and regional bureaus; and other bilateral and multilateral donors. MEASURE will build the capacity of these customers to demand quality data; define their data needs; determine the most appropriate and cost-effective method for collecting the data; analyze and understand the implications of the data; and most importantly, translate and use the data for program planning, policymaking, and management. The MEASURE Phase II partners will work with a variety of other partners including bilateral and multilateral donors, other CAs, PVOs, NGOs, etc. They will work with these partners to coordinate data collection activities, improve the efficiency of data collection and improve the use of data for program planning and policymaking.

PART II. PROGRAM DESCRIPTION FOR THE MEASURE PHASE II COOPERATIVE AGREEMENT (RFA)

I. Introduction

The MEASURE Phase II Cooperative Agreement is USAID/GH's primary vehicle for supporting technical assistance, capacity building, and research in monitoring and evaluation in the PHN sector. Under this Cooperative Agreement, the applicant's principal mandate is to be innovative in defining and implementing its research, technical assistance and capacity building agenda in response to host-country and global needs, as circumscribed by the boundaries of USAID Agency objectives and the MEASURE Phase II, guiding principles (found in Section V., Background, III.B), activity objective, intermediate results, and funding requirements. This activity will also provide a

leadership role in identifying research and information gaps and priorities in response to increasing data needs, evolving priorities, and more constrained resources. Assessing the cost-effectiveness of alternative options for M&E of host country programs will play an important role in technical assistance efforts. In the design and implementation of its M&E strategies and annual workplans, the recipient will provide leadership in leveraging resources and in working in close coordination with the other MEASURE Phase II partners and the international PHN community, including multilateral and bilateral donors, USAID Global Health Cooperating Agencies (CAs), PVOs and NGOs, and research and training institutions. The ultimate objective of these efforts will be to optimize data and information use from M&E activities in host countries in program planning, management, policy-making and implementation, thereby achieving a greater impact on health outcomes.

A critical element in the design of the MEASURE Phase II Cooperative Agreement is the increased emphasis on the importance of ***planning for data use***. Improving data quality and working closely with potential data users from the earliest stages of the data collection process will increase the probability of data being used to develop programs and policies that will ultimately have impact on health outcomes. Planning for data use requires a shift in emphasis towards activities that generate demand for high quality data, improve the process of data collection and analysis, increase the availability and accessibility of data, and facilitate the use of M&E data for program and policy development and modification.

The MEASURE Phase II Cooperative Agreement is designed to be responsive to changes in requirements for program monitoring and evaluation as a result of new guidelines and directives set forth for USAID PHN programming. Such changes in PHN programming include but are not limited to: 1) shifting priorities and corresponding funding flows in population and health sub-sector areas, such as HIV/AIDS, infectious disease, maternal and child health, and adult morbidity and mortality; 2) integration of programming, such as family planning/RH and HIV/AIDS; 3) requirements for data at sub-national levels as a result of decentralization and health care reform; 4) measurement requirements for poverty reduction and equity objectives and initiatives; 5) emerging issues as varied as integration of child health and tuberculosis programs, and technical assistance in complex emergencies; and 6) a redirected focus on data generation to ensure that data users' needs are being met to achieve a greater use of data in program and policy development. The preceding list is illustrative and by no means intended to be exhaustive.

These emerging issues in health programming across sub-sectors and at multiple levels of the health system illustrate that monitoring and evaluation needs have become more complex. Program monitoring and impact information are required by a more diverse audience of users, both internal and external to the health system, and over different timeframes. In response to these new requirements, technical assistance will be required to develop new and affordable methods, tools, and guidelines for collecting and analyzing data, and for the transfer of competencies in their application.

Technical assistance will also be required to address the varied components and stages of M&E planning, including the development of a monitoring and evaluation plan, implementation of a new system or revision of existing systems, and analysis and use of the data.

II. Cooperative Agreement Overview

The MEASURE Phase II Cooperative Agreement is one of four components of the MEASURE Phase II Activity previously described in the BACKGROUND section. As such, the recipient will work closely with the other MEASURE Phase II partners to coordinate efforts in strategic planning, work plan development and implementation, design and implementation of capacity building strategies and activities, facilitation of data use, and leveraging of financial support from non-USAID sources.

This Cooperative Agreement will: generate demand for high quality M&E information; provide leadership to data users to prioritize data needs; identify research gaps and undertake evaluation research; develop new and refine existing tools, guidelines and approaches for monitoring and evaluating PHN programs; develop capacity among data producers and users in M&E principles, planning, methods and analysis; disseminate M&E best practices; conduct special studies; and facilitate use of M&E data and information. The recipient will ensure that its work is responsive to clients' needs and will communicate and disseminate the findings using state of the art communication techniques targeted appropriately. The research, technical assistance, and capacity building agenda and work plans under the Cooperative Agreement will be developed and revised on an annual basis and will be responsive to evolving USAID/W and field strategic objective priorities and funding resources.

Throughout the process of providing technical assistance, the recipient will work with **counterparts and data users** to assess approaches based on cost, quality, and scope criteria. It is expected that a broad range of methods and tools will be **developed and applied** across programs for data collection and analysis. Methods of interest might include population and facility surveys, routine health information systems, vital registration systems, qualitative methods, Priorities for Local AIDS Control Efforts (PLACE) methods, surveillance, and others as necessary. Revision and testing of existing methods and tools may also be conducted. Strategies and interventions will also be implemented for creating data demand, increasing data availability, and facilitating data use.

Cross-cutting priorities for the Bureau of Global Health and the field will also be incorporated into the Cooperative Agreement's annual workplans and could include measurement, monitoring and evaluation of initiatives in: 1) gender, 2) poverty reduction and equity, 3) health care reform and decentralization, 4) sub-sector and multi-sector program integration, 5) PVO/NGO program monitoring and evaluation, 6) public–private partnerships, and 7) emerging issues in adult morbidity and mortality. In addition, a critical role of the Cooperative Agreement recipient will be to provide assistance in developing, collecting information on, synthesizing, and sharing **lessons learned and**

best practices vis-à-vis core-funded, field-supported, and bilateral program M&E systems.

1. USAID Management

A GH staff member will act as Cognizant Technical Officer (CTO) for the MEASURE Phase II Cooperative Agreement. It is anticipated that the CTO will be assisted by Technical Advisors from each of the three Technical Offices in providing management and technical oversight. In this way, USAID will assume a technical as well as managerial leadership role in providing oversight for the Cooperative Agreement's work across all of the SO areas, and more generally in support of cross-Bureau "common agenda" activities. The Cooperative Agreement CTO and Technical Advisors, along with all other MEASURE Phase II CTOs and Technical Advisors, will constitute the USAID MEASURE Phase II Management Team.

2. Beneficiaries

The principal beneficiaries of the MEASURE Phase II Cooperative Agreement are individuals, organizations, and institutions, in both the public and private sector, in USAID-supported countries. They also include USAID and its Missions and the international community of donors, cooperating agencies, PVOs and NGOs, research institutions, advocacy groups, media, and other non-technical audiences. In some cases, these beneficiaries may also be implementing partners. In working with beneficiaries, the focus will be on optimizing data use through building monitoring and evaluation capacity at all levels of the health system across PHN sub-sectors in USAID-supported countries. Transfer of competencies in monitoring and evaluating of PHN programs will be reflected through improvements in the demand for and use of data across the spectrum of principal beneficiaries identified above.

III. Program Description

I. Activity Objective and Intermediate Results

<u>Activity Objective</u>: Improved collection, analysis and presentation of data to promote better use of data in planning, policymaking, managing, monitoring and evaluating population, health and nutrition programs.

The Activity Objective for the overall MEASURE Phase II activity and for this Cooperative Agreement is one and the same. The MEASURE Phase II Cooperative Agreement is not expected to achieve the Activity Objective on its own. However, it is expected to make a significant contribution, as well as collaborate with the other MEASURE Phase II partners, to achieve this Objective.

MEASURE Phase II has been developed on the premise that generating demand for appropriate data and improving the use of data in policy formulation, program planning, management, and monitoring and evaluation improves health services and consequently,

health outcomes. In order to achieve this, there is a continuum of activities that must be implemented. These include generating demand for relevant data and collecting, analyzing, disseminating, and using data. The MEASURE Phase II Cooperative Agreement is expected to plan and implement an integrated, synergistic program of activities across this continuum. This continuum is reflected in the six results of MEASURE Phase II. A description of the role the Cooperative Agreement will play in achieving each result is reflected in the discussion below.

Health professionals who understand the role and importance of high quality data are able to use it to identify critical health needs, develop policy, design and manage programs that address their specific needs, monitor performance, and demonstrate the results of their programs. Obtaining high quality data in developing countries is a highly complex process. Technical experts who understand this complexity must use their expertise to: help health professionals and other data users understand the strengths and limitations of various indicators; recognize the tradeoffs of various data collection approaches in terms of cost, management burden, validity, reliability, and time; and select the most cost-effective data collection approach. Consequently, it is critical that technical experts work with data users to define and prioritize their information needs and develop and implement more cost-effective and speedier data collection approaches. Skillful data analysis and reporting aids in ensuring that the collected data are used to evaluate programs and improve understanding of health status, health-seeking behavior, health service utilization as well as health care provision. Finally, effective data presentation is essential to ensure that information reaches the planners, policymakers and program managers for use in evidence-based decisions.

It is also important to build a sustainable capacity of the data demand, collection, analysis, dissemination and use processes in-country. The MEASURE Phase II Cooperative Agreement activities should be implemented in a way that intentionally builds capacity of both men and women to contribute to these processes. They must also be implemented in a manner that strengthens our understanding of gender and how it influences health status, health seeking behavior, and health program effectiveness.

The guiding principles described in the Background section and the six results of the MEASURE Phase II Activity described below have been developed to achieve the overall Activity Objective. The following section describes the contribution of the MEASURE PHASE II Cooperative Agreement to these results. It does not present the contributions of the other MEASURE Phase II Partners; these are discussed in the RFP for the MEASURE Phase II DHS Contract and the BUCEN and CDC Participating Agency Services Agreements.

Result 1 Increased user demand for quality information, methods, and tools.

Increased user demand is a new emphasis in MEASURE Phase II. Although in MEASURE Phase I, MEASURE Evaluation certainly stimulated user interest in better information for monitoring and evaluating programs, it was more a by-product of its efforts than an intentional focus. What has become clear, however, in the course of

MEASURE Phase I, is the integral role the demand for quality information plays in the ultimate use of data. Achieving this result will help answer questions about the lack of user demand and ways to increase the demand. With this knowledge the MEASURE Phase II Cooperative Agreement will illustrate the importance that the role of increasing user demand plays in the use of high quality information, methods, and tools for evidence-based program planning, policymaking, and management.

The implementer of the Cooperative Agreement will strive to understand the perceptions, constraints, and stigmas that inhibit data demand, including: lack of users included in the identification of data needs, obstacles in the flow of various information systems, knowledge barriers and lack of understanding of the value of data, and individual as well as structural or systemic incentives or disincentives for using data. Understanding both the perceived and real constraints will enable better development of data systems and tools that will meet and increase user demand as well as ensure ownership of the data and thus future use.

A strategic approach is needed to increase user demand for data and information. It is essential that this Cooperative Agreement work closely with those involved in technical implementation as well as in data collection in implementing the approaches for increasing user demand for data. This will mean coordinating with MEASURE Phase II partners, and in other cases, with other CAs, PVOs/NGOs, other donor agencies, or host-country counterparts who are engaged in collecting data.

In some countries, demand generation activities may need to be funded initially by Core funds because the demand generation activities are a new emphasis to MEASURE Phase II. However, as these activities, become a more regular and well-accepted part of the Cooperative Agreement's overall approach, it is expected that these activities will begin to be funded through a country Mission's field support.

[Applicants should describe the strategic approach they would use to address the issue of increasing demand for quality data, information, methods and tools, including but not limited to strategies and illustrative activities for the following: identifying users and potential users of data/information and for assessing their unmet data/information needs; determining the constraints to data use among potential target audiences and data user groups; and coordinating with other partners in these demand building efforts. This strategic approach should be based on a sound, well-articulated rationale.]

<u>Result 2</u> Increased in-country individual and institutional technical <u>capacity</u> and resources for the identification of data needs and the collection, analysis and communication of appropriate information to meet those needs.

The increasing demand for data is paralleled by an equally increasing demand for public health professionals with PHN program monitoring and evaluation knowledge and skills. Currently there are few training and educational institutions in developing countries offering either formal or informal training opportunities in M&E of public health

programs. In institutions where training does exist, traditional teaching methods often use a didactic approach that is little suited to teaching the application of new skills, thereby decreasing the effectiveness of the training. In addition, trainees typically have inadequate opportunities to apply newly acquired skills and knowledge when they return to their place of work. Ongoing individual mentoring and institutional support, which are critical components of successful training programs, are lacking. The inadequacy of both theoretical and applied M&E educational and training opportunities has resulted in insufficient numbers of trained monitoring and evaluation specialists in the health sector.

Host-country partners and other major donor agencies are recognizing the shortage of well-prepared monitoring and evaluation professionals and are speaking out on the tremendous need for capacity building. The challenge is how to create this capacity, modeling innovative and cost effective training methods, in adequate numbers in a resource poor environment.

The MEASURE Phase II Cooperative Agreement will build upon the foundation laid during MEASURE Phase I to build sustainable host-country capacity to identify data needs and collect, analyze, and present data for use in advocacy, planning, policymaking, managing, and monitoring and evaluation of population, health, and nutrition programs. It is important that capacity building content covers the full range of monitoring and evaluation concepts and skills and addresses the important areas of generating user demand (Result 1), making data available (Result 5) and facilitating their use (Result 6). Also, it is desirable that capacity building content includes the introduction and effective use of both newly developed and existing tools and methods.

MEASURE Phase II will continue to address capacity building at both the institutional and individual levels. Strong institutional relationships developed in Phase I are described below, however institutional relationships in Phase II need not be limited to those established during Phase I. A measure of the success of this Result will be that individual beneficiaries of capacity building efforts are strategically placed within host country and international partner institutions such that the new M&E skills and knowledge gained through training and educational opportunities are optimally applied in the work place. In keeping with development goals, the ultimate objective for capacity building and institutional development activities is the achievement of sustained capacity by partner institutions to independently provide monitoring and evaluation technical assistance and training in the absence of USAID assistance. A key development in achieving progress toward sustained capacity will include resource mobilization to sustain financing of monitoring and evaluation activities and capacity building in host countries.

During MEASURE Evaluation Phase I, emphasis has been placed on building partnerships with key regional training institutions and universities. These efforts have focused on building institutional and individual capacity in basic monitoring and evaluation concepts and skills for PHN programs. In addition, some regional training has focused on specific M&E issues such as the development and implementation of a monitoring and evaluation plan for national HIV/AIDS programs and impact evaluation

methods. MEASURE Communication also formed a training relationship with some of the same regional institutions for training in dissemination of monitoring and evaluation results. Listed below are the key partner institutions under MEASURE Evaluation Phase I for short-term regional training and for Master's programs with an M&E focus.

Short-term regional training

1. CESAG, Centre Africain d'Etudes Superieures en Gestion, Senegal
2. University of Costa Rica
3. Makere University, Uganda
4. Mahidol University, Thailand
5. East-West Center, Hawaii

Master's programs with an M&E focus

1. University of Costa Rica
2. Mahidol University, Thailand
3. University of Pretoria, South Africa

More detailed information on these and other M&E capacity building efforts can be obtained by consulting the MEASURE Evaluation website (www.cpc.unc.edu.measure) and the MEASURE Communication website (www.measurecommunication.org).

Although much has been accomplished through the introduction of the regional workshops and MPH programs, there remain opportunities for development of additional short-term capacity building activities. These are likely to focus on building M&E skills and knowledge relating to specialized topics. Illustrative examples are: monitoring and evaluation of TB programs, rapid assessment tools for community health and reproductive health quality of care, integration of vertical health information systems, measurement of sustainability and health system capacity, and management of monitoring and evaluation systems.

Development of tools and methodologies for capacity building as well as curricula development may be funded with Core funds. Funding for participants is expected to come from USAID mission funds and/or funds from non-USAID sources. Despite these anticipated sources of external funds, a major element of a sustainable effort to build M&E capacity must include a plan for cost recovery, or at a minimum, financial diversification.

[Applicants should outline a comprehensive, strategic M&E capacity building plan that addresses the issues that are identified above, including, but not limited to: specific skill areas to be addressed through M&E capacity building; target groups and beneficiaries for capacity building efforts; differing needs for capacity-building across the GH Bureau's five health SOs; trainee follow-up; short-term and long-term capacity building approaches; strategies for introducing, disseminating and encouraging use of new and existing tools and

methods; coordination and collaboration in capacity building efforts with partners; and resource diversification, cost recovery and sustainability.]

Result 3 Increased collaboration and coordination in efforts to obtain and communicate health, population and nutrition data in areas of mutual interest.

MEASURE Phase II will collaborate and coordinate its activities, as appropriate, at all levels of the health system and internationally with host-country partners, other MEASURE partners, USAID/CAs, non-governmental organizations, implementing partners of bilateral and multilateral agencies and with its USAID partners (Field, Regional and Global levels).

Collaboration and coordination are even more important now than in the past as data needs are expanding due to the increasing emphasis on data-based decision making; demonstration of program results; and new areas of program interventions, such as infectious disease, crisis response, and poverty reduction to name a few. In addition, data are needed at many different levels, sub-national, national and global, and by a multitude of partners with very different objectives for data use. Frequently a variety of different users require data on the same programmatic areas. Collaboration and coordination among data users and providers are critical to ensure comparability of data within and across national borders, to more effectively make use of scarce resources for monitoring and evaluation, and to reduce the burden on host countries resulting from a variety of actors with similar data needs. Efficiency in efforts to obtain and communicate health, population and nutrition data will be improved by intentional and strategic efforts to collaboration and coordinate in achieving this result.

Under MEASURE Phase I, USAID placed special emphasis on the collaboration and coordination of data collection, monitoring and evaluation, and dissemination efforts. MEASURE Evaluation was expected to play a particularly important role in promoting coordination and collaboration. Indeed, a number of key collaborative and coordinated efforts have occurred under MEASURE Phase I, both among MEASURE partners as well as with outside partners and collaborators.

Collaboration among the MEASURE partners has taken several different paths. Some of these are described below accompanied by specific examples.

Collaboration among MEASURE partners: The development and implementation of joint work plans among the MEASURE partners in the field, as appropriate, has been a priority under MEASURE Phase I, and has in many cases, resulted in important and innovative partnerships. Simultaneous fielding of the Nicaragua DHS+ population-based survey and the MEASURE Evaluation facility-based survey provided information to assess the effect of Hurricane Mitch on the population's health status and the success of the health system's reconstruction efforts following the hurricane. MEASURE DHS+ and MEASURE Evaluation also worked closely together on the development of modules for HIV/AIDS and Malaria to be implemented in population-based surveys. Other collaborative activities among the partners have been an outgrowth of shared

participation in working groups such as the training, facility survey and GIS working groups.

Collaboration with Bureau for Global Health partners: MEASURE Evaluation is assisting the Global Health's Office of Health, Infectious Disease and Nutrition, Infectious Disease Division in designing an M&E plan to monitor the Division's activities throughout the developing world. This work includes close collaboration with USAID Global staff and WHO staff in the Stop TB and the Roll Back Malaria initiatives. MEASURE Evaluation is also proving technical assistance to the Bureaus' HIV/AIDS/Family Planning Integration Working Group in the development of a framework and monitoring and evaluation plan for the Working Group's global program. Under the same technical assistance package, MEASURE Evaluation is participating in a study with other Global Health partners in documenting the relative impact of abstinence, behavior change and condom use (ABC) on HIV prevalence trends in selected countries.

Collaboration within host country partners: The provision of technical assistance in M&E is closely connected to program implementation and thus with implementation partners. Effective collaboration and coordination ensure that the types of data collected and the indicators measured are consistent with strategic frameworks and program objectives. In Bangladesh, Uganda, and Nigeria, MEASURE Evaluation is working in partnership with the reproductive health bilateral and host country partners to monitor, and in some cases, undertake impact evaluations of the bi-lateral program. Depending upon the specific program objectives and results, special attention is being paid in data collection efforts to assessing equity in service use outcomes or improvements in quality of care. In South Africa MEASURE Evaluation is designing and implementing an M&E plan to provide information on regional cross border HIV prevention activities. All of these activities have required extensive collaboration with implementers representing a range of partners, including USAID/CAs, local NGO's, MOH partners, host country research facilities, USAID mission and regional staff, and other donors in-country.

Collaboration with international partners: MEASURE Evaluation has been a global leader in the development and implementation of monitoring and evaluation frameworks, guidelines, tools and methodologies for the broad spectrum of population, health and nutrition programs and interventions. Most recently, MEASURE Evaluation has spearheaded highly collaborative and coordinated efforts to develop guidelines for and implement monitoring and evaluation plans of the HIV/AIDS global epidemic. Specifically, MEASURE Evaluation provided technical assistance and led in developing the coalition of international partners (UNAIDS, USAID, WHO, World Bank, UNICEF and CDC) in the development of the *National AIDS Programmes: A Guide to Monitoring and Evaluation Guide*.

Other outstanding examples of MEASURE Evaluation's coordination and collaboration leadership include the development and production of the two volume *Compendium of Indicators for Evaluating Reproductive Health Programs*, and the initiation and ongoing technical support to the international coalition network entitled *RHINO* (Routine Health Information Network). MEASURE Evaluation has worked with UNAIDS, UNICEF,

WHO, CDC, and the World Bank in many other PHN areas to identify information gaps, prioritize research needs, and conduct strategic planning of monitoring and evaluation of global health programs.

Many of Global Health's implementing partners are currently working in the area of monitoring and evaluation for their specific technical areas. An issue that has not been well addressed during MEASURE Phase I is the establishment of the role that the Cooperative Agreement can play in facilitating the ongoing work of GH CAs and also how the Cooperative Agreement can learn from the work that these CAs are conducting. Another relatively unexplored area is how the MEASURE M&E technical leadership role is defined vis-à-vis that of a number of Global Bureau CAs whose mandates may partly overlap with that of the MEASURE Phase II Cooperative Agreement.

It is expected that MEASURE Phase II will build on and expand the work of collaboration and coordination begun in MEASURE Phase I.

[Applicants should outline strategies and illustrative activities for ensuring field-level and international collaboration and coordination with various relevant partners. In particular, the application should discuss what staff positions, structures and systems will be put into place to promote field and international coordination and collaboration in monitoring and evaluation research, technical assistance, planning and capacity building. In addition, Applicants should identify CAs, NGOs and PVOs, and global projects with overlapping mandates in M&E, data use, and communication and dissemination, and accordingly provide strategies and illustrative activities for optimizing collaboration and coordination with these partners and projects.]

<u>Result 4</u> Improved <u>design and implementation</u> of the information gathering process including tools, methodologies and technical guidance to meet users' needs.

The need for this Result rests on the ever-expanding requirements for data to inform policy, planning, and management decisions in the developing world public health sector. Data needs are quickly increasing at sub-national levels due to decentralization of health care systems. Fragile, outdated or non-existent routine health information and vital registration systems compound the problem. Additionally, global initiatives require the ability to aggregate national data to the global level and to compare data across countries and regions. Thus work in Result 4 addresses monitoring and evaluation issues ranging from local area PHN programs, through to sub-national, national, and global levels.

Activities under this result are at the core of the technical work of the cooperative agreement, and will involve research on and development of new monitoring and evaluation methods and tools as well as examining existing untested methods. Activities may also include conducting formative and impact evaluation in USAID priority PHN areas, i.e., the Agency's five strategic objectives and health system performance. As with all the results under MEASURE Phase II, an understanding of the needs of data users should guide the design and implementation of the information gathering process.

Furthermore, it is desirable that collaboration and coordination as appropriate (see Result 3) would occur in achieving Result 4.

A pre-design evaluation of MEASURE Phase I identified a lack of balance among the measurement methods and related tools developed and implemented by the MEASURE partners. The evaluation team cited an over-emphasis on the use of survey methodologies in MEASURE Phase I. Understandably, given urgent data needs and the lack of reliable information systems, survey methods have been relied upon to provide critical data. The challenge is to design (or re-design), and implement methods to systematically provide valid, reliable and cost-effective data. A separate challenge is to meet the need for rapid, flexible and cost-effective data collection methods, while keeping in mind the ultimate objective of providing information that is responsive to end-users' needs. Survey methods continue to have importance but, in the interests of developing an information culture in the developing world, should not always be the primary source of data.

During Phase I, MEASURE Evaluation has played a leadership role in improving tools and methods in PHN monitoring and evaluation. This leadership has resulted in innovations such a the development of the "world standard" technical guidance for monitoring and evaluating HIV/AIDS programs in collaboration with CDC, UNAIDS, WHO, and others; and the development of new tools and approaches for data collection, such as the Quick Investigation of Quality (QIQ) and the Priorities for Local AIDS Control Efforts (PLACE) methodologies. MEASURE Evaluation has been a leader in the development of facility surveys and in sexual behavior surveys for HIV/AIDS and STDs. It has also been on the forefront of developing and applying new analytic methods to existing survey data to address issues such as the impact of economic crisis on service use and methods for monitoring contraceptive continuation and its links to fertility outcomes and quality of care.

Examples of MEASURE Evaluation Phase I field activities that represent new tool and method development include the following: MEASURE Evaluation is currently working with the Haitian Ministry of Health in developing a model routine health information system and a strategic plan for implementing the same. In Pakistan MEASURE Evaluation has developed a curriculum and plans to implement a training program in routine health information systems for district medical officers. In Kenya, MEASURE Evaluation is working on the development of a short instrument to respond to the need for a more rapid district quality of care assessment tool.

Additionally, MEASURE Evaluation has provided technical assistance to a number of USAID missions in the development of their performance management plans (PMPs). In the case of USAID/CAR (the Central Asian Republics), the cooperative agreement has worked with the Mission to develop an innovative database for its PMP. In Nigeria, technical assistance for the PMP development included a training of implementing partners and host-country M&E partners in the essentials of performance monitoring plan development and implementation. South-to-South technical assistance was effectively accomplished through the MEASURE Evaluation Phase I oversight and support of the

Mexican National Institute of Public Health assistance to Peru in evaluation of adolescent health programs. However, the area of support for South to South technical assistance would benefit from further development and expansion in the MEASURE Cooperative Agreement in Phase II.

Many of the activities related to this result are likely to require Core funding and, in part, will be dependent on the availability of funds.

[Applicants should present a draft research and development agenda that covers the full range of the PHN sector and highlights what they see as the key areas of pursuit for the Cooperative Agreement as part of MEASURE Phase II. As part of this plan, Applicants should indicate: what criteria would be used for selection of new research and tool development topics, how the research and development agenda under the cooperative agreement complements other worldwide efforts, how they would partner with other groups in R&D efforts, and how capacity building will be incorporated into the work that focuses on this result.]

Result 5 Increased availability of population, health, and nutrition data, analyses, methods and tools.

Result 6 Increased facilitation of use of health, population and nutrition data

Increasing the availability of health data in appropriate formats (Result 5) is an important first step in facilitating the use of these data for program planning and policymaking (Result 6).

Increasing availability of data and information (i.e., presenting data and other project products in forms that are acceptable, understandable, and useful to identified user groups) requires an understanding of the constraints on increased availability/access by potential as well as current user groups and is critical to achieving the desired behavioral change of moving to a culture of information use. In addition to physical access, factors constraining availability include, among others: timeliness of reporting and user attributes such as technical skills, knowledge and understanding, educational background, socio-economic factors, gender, language, cultural beliefs and practices. A lack of pro-active planning for data and product availability can also be attributed to the different paradigms operating within the scientific community that contribute to a lack of coordination and collaboration. The appropriateness of the proposed dissemination format, media, and channels of distribution (i.e., mass media, internet, mailing, conferences etc.) also must be taken into account in attempting to overcome these availability constraints.

Facilitating data use requires an understanding of the constraints to data use, keeping in mind that obstacles may exist at many different points: a potential user's insufficient interest in or awareness of how data could be used; lack of availability and access to data; and a lack of skills and knowledge of data analysis, interpretation and presentation. In addition, some constraints may lie outside the user. These “structural constraints” could

include cultural, political, and gender systems, as well as others. Careful analyses of all of the constraints to use will be key to developing strategies for overcoming them.

Translating data into relevant information and presenting it to the intended target audience is the first phase to facilitating use of data for policymaking, program planning, and management. The next phase requires working with data users to help them actually use the data. Experience under MEASURE Phase I demonstrated that the data demand generation–collection–use continuum requires extensive interaction between data collectors and data users. It also demonstrated that supporting dissemination efforts through a separate, stand-alone procurement can lead to disconnects between data users and data collectors and discontinuities in project implementation. While each MEASURE Phase II partner is responsible for translation and dissemination of the data that it collects and analyzes as well as the tools and methodologies that it develops, the partners must also work together and with other implementing organizations. As with other aspects of the Cooperative Agreement's work, this process will require the formation of partnerships early on to facilitate broad and multiple end uses of generated data and information.

The role and responsibilities of MEASURE Phase II cooperative agreement in achieving Result 6 will largely depend on the context of specific activities. When facilitation of data use is closely aligned with an activity such as implementation of a program monitoring system, MEASURE Evaluation Phase II would have the responsibility to ensure that users have the technical skills to process emerging data into project planning and performance assessment and other decision-making activities. In other instances, however, its responsibility may be largely that of coordinating with others and ensuring that data are made available to host country partners, other CAs, NGOs, stakeholders or other donors who will carry forward with facilitating data use. An important aspect of facilitating data use for the Cooperative Agreement will be to link in-country data users with other GH CAs, donor organizations, PVOs, NGOs, and advocacy and policy groups.

Under the MEASURE Phase I Evaluation cooperative agreement, there have been some excellent cases of facilitation of use of PHN data. These include the monitoring system that was set up in Turkey to help improve quality of reproductive health care and the PLACE method to identify high HIV transmission areas, thus enabling targeting of key prevention intervention sites in South Africa. However, facilitation of data use was not a well-articulated expectation for any of the MEASURE Phase I partners, including MEASURE Evaluation, and thus it did not always happen to the extent desirable. A new focus in Phase II and arguably the most important result is Result 6, increased facilitation of data use, because the use of data is the fundamental basis of the rationale for the MEASURE Phase II program.

Some of the MEASURE Phase II Cooperative Agreement's efforts to facilitate use of data, tools and methods may be Core funded or funded jointly through other GH projects. The expectation is, however, that once Missions and other donors see the benefits derived from the focus on facilitation of use, they will be willing to assume the costs for these activities.

[Applicants should choose a topic of emerging interest and prepare an illustrative data dissemination plan that focuses on enhancing the availability of data collected by this Agreement that are relevant to the topic.]

[Applicants should present a strategy for data "translation" and facilitation of data use that reflects their expertise in state-of-the-art techniques as well as current technologies. This strategy should describe the approach for identifying and reaching target audiences; the methods and approaches used to facilitate data, information and tool use; the partners involved in the facilitation activity according to target audience and end use; and the types of activities that will be developed to address constraints. The strategy should also discuss how the applicant will monitor progress towards increasing use of data in program planning, management, and policy making. Applicants should also discuss how they would encourage USAID missions and other partners to value and support these data, information and tool "translation" and use activities.]

II. Implementation

1. Country Selection

Cooperative Agreement resources will be available in all geographic regions. The actual selection of countries will depend in large part on mission demand and field support funding. Final selection will be made jointly by the CTO/TAs and the MEASURE Phase II RFA Recipient.

For budgeting purposes Applicants should assume that the MEASURE Phase II Cooperative Agreement will work in approximately 30 countries over five years from the illustrative list of countries below.

South Africa	Bangladesh	Brazil
Ghana	Egypt	Haiti
Kenya	Indonesia	Mexico
Nigeria	Nepal	Ecuador
Sudan	Philippines	Guatemala
Tanzania	Cambodia	Nicaragua
Uganda	Pakistan	G/CAP
DR Congo	Afghanistan	Jamaica
Rwanda	West Bank/Gaza	Bolivia
Zambia	India	
Benin		
Eritrea	Russia	
Guinea	Central Asia Republics	
Madagascar	Ukraine	
Mali		
Malawi		

2. Country Strategies

Country-based activities implemented under this Agreement will flow from the mission-approved country strategy and performance monitoring plan. For each country in which activities are implemented, the Recipient will prepare a written comprehensive, country-specific strategy. This strategy will make the best use of limited data collection, analysis, dissemination and data use resources, after consulting with mission staff, local counterparts, other MEASURE Phase II partners, other donors and CAs working in country and GH staff.

Each country strategy document will address certain common elements:

- a description of how the activities contribute to the achievement of the mission SO and IRs;
- expected outputs and results;
- indicators and targets for monitoring the performance of the Cooperative Agreement;
- a plan for working with the primary in-country client(s) (i.e. the MOH, the USAID mission, other donors, private sector providers etc.);
- a plan for working with the other MEASURE Phase II partners and other donors in country;
- a plan for working with other CAs in country to help ensure that the data collected will eventually be used to improve policymaking, program planning and management;
- a data availability, dissemination and facilitation of use component;
- a capacity building component; and
- any sub-grants that may be needed.

The following GH projects are likely to be active in some, if not all, of the same countries as the MEASURE Phase II Cooperative Agreement. The Recipient is expected to identify ways to collaborate with these groups to promote the use of data for program planning, management, and policymaking. The list is suggestive but not exhaustive of the projects with which the Cooperative Agreement will collaborate.

MEASURE and its component partners – the MEASURE Phase II DHS Contract, the MEASURE Phase II Cooperative Agreement, the Bureau of Census PASA and the CDC PASA – improved collection, analysis and presentation of data to promote better planning, policymaking, managing, monitoring and evaluating of population, health and nutrition programs.
POLICY II - to promote the use of monitoring and evaluation data in the development of improved policies that strengthen reproductive and maternal health services and promote prevention of HIV/AIDS.
PHR Plus – to promote the use of monitoring and evaluation data in the development of health sector reform strategies that strengthen health services and promote prevention of HIV/AIDS.

YOUTHNET – to ensure that data are used to improve understanding of the needs of adolescents as well as to improve health services to better meet their special needs.
Management and Leadership – to strengthen the ability of NGOs to use data for planning, managing and monitoring and evaluating health programs.
FRONTIERS *and* ***HORIZONS*** – to identify data needs and ensure that monitoring and evaluation data that are collected by the MEASURE Phase II Cooperative Agreement are used to inform the development of operations research studies.
SYNERGY – to share the HIV/AIDS-related monitoring and evaluation data collected by the MEASURE Phase II Cooperative Agreement with other CAs.
Health Logistics Assistance Projects (DELIVER and RPM) – to ensure that monitoring and evaluation data are collected to ensure a reliable commodity supply.
Maternal and Neonatal Health Project – to ensure that appropriate data are collected for improving maternal survival interventions.
CHANGE – *to promote the use of data collected by the MEASURE Phase II Cooperative Agreement in behavior change interventions.*
TEPHINET – to promote the use of methodologies developed by and data collected by the MEASURE Phase II Cooperative Agreement in the monitoring of TB.
EHPII - to promote the use of data collected by the MEASURE Phase II Cooperative Agreement in the reduction of environmentally related mortality and morbidity.
IMPACT – to promote the use of data collected by the MEASURE Phase II Cooperative Agreement in the implementation of interventions to prevent transmission of HIV/AIDS.
BASICS II - to identify data needs and help ensure that data that are collected by the MEASURE Phase II Cooperative Agreement are used to improve child health.
The Quality Assurance Project - to identify data needs and help ensure that data that are collected by the MEASURE Phase II Cooperative Agreement are used to inform the development of quality assurance efforts.
The Health Communication Partnership - to improve the use of data to develop effective health communication efforts.
INFO – to disseminate best practices for population- and facility-based data collection and other tools and methodologies developed under the MEASURE Phase Cooperative Agreement**.**

In the context of the country strategy, the Recipient will draft annual workplans for each country in which a substantial amount of work is to be undertaken (i.e., multi-year work or work totaling over $100,000). The workplan will specify the kinds of technical assistance that will be provided, the counterparts (public, private and NGO) that will be involved in the activities, the research and data analyses that will be conducted, the timeline, anticipated dissemination products and expected results. The workplan should describe how the Recipient plans to work with other donors and other USAID-funded projects that are active in the country. The country workplans will be compiled into the Project's annual workplan that will be shared with the other MEASURE Phase II partners, reviewed by the USAID MEASURE team, and approved by missions and the CTO/TAs.

[Applicants should provide a sample country strategy, including illustrative indicators, for one of the countries listed above that covers the elements described

above. In particular, applicants should include a comprehensive data collection plan, a data dissemination, translation and use plan, and a capacity building plan, as well as a description of the process that would be used to develop such strategies and the project's internal review process for country strategies and activity products. Applicants should also describe how the evaluation criteria will be developed and monitored for each country strategy.]

3. Use of Core Funds

There are a number of areas in which this project will contribute to the following critical functions of GH -- global leadership, research and evaluation, and technical support to the field. These include assistance to other GH CAs with monitoring and evaluation plans, improved and more cost-effective M&E methodologies, technical and global leadership across the six Results, improved collaboration and coordination with other MEASURE Phase II partners and other donors, and global publications. The MEASURE Phase II Cooperative Agreement will be expected to show the linkage between such activities and the GH Bureau's strategic objectives.

[Applicants should present an illustrative strategy for the use of core funds. For application purposes, applicants should assume they will receive core funds from all five GH SOs in the following proportions: $xx SO1; $xx SO2; $xx SO3; $xx SO4; and $xx SO5. The strategy should propose activities that would be relevant across all SOs and illustrative SO-specific activities.]

4. Monitoring and Evaluation

As a leader in the field of monitoring and evaluation, the implementer of the Cooperative Agreement should be exemplary in their approach to monitoring and evaluating their own efforts under this Cooperative Agreement. Thus, the Recipient should clearly articulate what is to be accomplished under each Result under the Activity Objective and devise a plan for monitoring those accomplishments. Developing a system to enable the Cooperative Agreement to track results and use this information to make management decisions will require a commitment of core funds and staff. However, this system will greatly facilitate coordination with the other MEASURE Phase II partners and annual reporting, and will serve as both the internal and the external monitoring system.

There may be times during the course of this Cooperative Agreement that in addition to the information provided through this monitoring system, more in-depth management reviews will be necessary. This determination will be made by the CTO for the Cooperative Agreement and will be conducted in a manner consistent with the Guidelines for Management Review.

[Applicants should lay out a strategic framework for the six Results under the MEASURE Phase II Activity Objective that demonstrates the contribution that the Cooperative Agreement is expected to make to each Result. In addition, Applicants should explain how they would define the relationship and contribution of their

work to the strategic frameworks of Missions in countries where they are working and USAID/ Washington GH strategic framework. At a minimum applicants should identify: Intermediate Results that would lead to their contribution toward achieving each of the six Results; illustrative activities that would lead to accomplishing Results and Intermediate Results and an indication of what would determine selection of the activities; indicators that would be used to monitor progress; and a detailed plan for how indicators will be tracked on an ongoing basis that will facilitate Results Reporting to USAID Washington and USAID Missions. Finally, Applicants should identify how they might collaborate with other MEASURE Phase II partners in efforts to monitor the progress of MEASURE Phase II overall.]

5. Management Plan

Co-ordination and communication with a wide range of partners will be key to the success of the MEASURE Phase II Cooperative Agreement. This coordination and communication will be internal, especially if there are multiple partners implementing the Cooperative Agreement, and external—with other MEASURE Phase II partners and multiple constituencies outside of the MEASURE activity, for example, USAID/Washington and Missions, other CAs, host-country counterparts, and other donors. One of the key challenges will be to manage these multiple levels of coordination and communication.

A management plan for the Cooperative Agreement will need to specify clear lines of supervision, decision-making, responsibility, and accountability among staff. In the case of a prime/sub relationship, particularly in the case of physical separation of the implementing institutions, clear lines of communication will need to be established. Special attention will need to be paid to ensuring efficiencies in operational and financial management because of the complicated funding scenario that is likely to exist for the Cooperative Agreement (i.e., many sources of funding requiring separate tracking).

[Applicants should outline their strategy for addressing key management challenges including but not limited to: internal and external coordination and communication, establishing lines of authority, financial management and decision making, and managing to ensure the achievement of the new and challenging demand and facilitation results.]

6. Staffing Plan

The applicant is invited to develop a comprehensive staffing plan that will enable achievement of the MEASURE PHASE II Cooperative Agreement Results and demonstrates an appropriate balance of ambition and accountability. It is anticipated that there will be adequate staff included in the staffing plan to conduct the functions of 1) project management 2) technical leadership and 3) support to management and technical staff.

The applicant should propose **at least** (but not limited to) three key personnel, among whom will be a Project Director, a Deputy Director and a Demand and Data Use Specialist. It will be incumbent upon the applicants to demonstrate in the proposed staffing plan that among themselves, the key personnel possess the technical, managerial and leadership expertise for the optimal achievement of the Cooperative Agreement Results. If a key personnel position is held by a staff member of a sub-recipient organization, the key staff member is expected to be physically based full-time in the offices of the prime signatory to the Cooperative Agreement. If additional key staff or alternatives are proposed, the applicant will provide the rationale for these positions.

The three key personnel positions are:

Project Director: The Project Director will have an advanced degree (Ph.D., Dr.P.H., M.D.); an additional MPH or MHS degree is desirable. The Project Director's responsibilities will include the overall planning and coordination of the Agreement's activities to include the work of any sub-recipients in the Agreement. The Project Director will provide management and technical leadership for the agreement and liaison between the Cooperative Agreement and USAID management. The Project Director is responsible for the quality of the Agreement's technical work and the management support systems.

The Project Director should posses technical leadership ability in monitoring and evaluation of public health programs in developing countries, including significant professional experience in building capacity within developing countries in monitoring and evaluation. The Project Director should have experience in managing large international cooperative agreements or contracts, some of which is with USAID-funded mechanisms. The Project Director will have extensive field experience in developing countries with an equally strong academic background. It is desirable that the Project Director has established professional relationships with the major multi-lateral donor and bilateral agencies.

The Project Director position is a full-time position. International travel should be at a level to ensure adequate oversight of Field activities and liaison with international agencies while maintaining involved supervision of the Agreement management functions. Language requirements: English required; fluency in French, Spanish is desirable. Additional languages: Arabic, Portuguese, and Russian,

Deputy Project Director will have an advanced degree (Ph.D., Dr.P.H., M.D.); an additional MPH or MHS degree is desirable. Relevant experience is substitutable for education. The Deputy Project Director will assist the Project Director in carrying out the oversight and management functions of the Agreement. S/He will assist the Project Director in the overall planning and coordination of the Agreement's activities to include the work of any sub-recipients to the Agreement. The Deputy Project Director will assume the responsibilities and duties of the Project Director when the Project Director is absent or unable to perform her/his duties and responsibilities.

Ideally the Deputy Project Director will have a technical background complementing that of the Project Director. Additionally the Deputy Project Director will have extensive in-country field experience (minimum 5 years) in monitoring and evaluation of population and health programs in developing countries and will be experienced in capacity building in monitoring and evaluation of population and health programs. The Deputy Project Director will also have demonstrated leadership qualities and experience in monitoring and evaluation as well as having demonstrated her/his ability to supervise technical, management and support staff. It is desirable that the Deputy Project Director has established professional relationships with the major multi-lateral donor and bilateral agencies.

The Deputy Project Director position is a full-time position. International travel should be at a level to ensure adequate oversight of field activities and liaison with international agencies while maintaining her/his project management functions and technical work. A minimum of 25% international travel is suggested. Language requirements: English required; fluency in French, Spanish is desirable. Additional languages: Arabic, Portuguese, and Russian.

Senior Technical Specialist: Demand and Data Use (DDU) : The creation of this key personnel position is directly linked to the importance attached to the two new result areas under MEASURE Phase II : Result 1: Increased user demand for quality information, methods, and tools; and Result 6: Increased facilitation of use of health, population and nutrition data. This person will also have oversight of activities related to Result 5 in order to ensure the link between availability and facilitation of use. The specialist should have an advanced degree in the technical area(s) consistent with the applicant's strategy for achieving these results. Preparation at the doctoral level with an additional MPH or MHS degree is desirable. The DDU Specialist will have extensive experience working in developing countries on activities focused on the demand for and use of data, information, and tools for policy development, program planning, management, monitoring and evaluation. S/he should be experienced in the application of communication theory to behavior change.

The DDU Specialist's technical knowledge base, skills and experience will include those necessary to engage in productive cross cultural communication and capacity building with individuals from a wide range of educational, professional and socio-economic backgrounds and professional objectives for seeking and using health data. S/he will have experience in the use of methods for communicating scientific data to stakeholders and non-professional advocacy groups. In addition to English, fluency in a second language is required. Suggested languages: French, Spanish, Arabic, Portuguese or Russian.

The DDU Specialist is a full-time position. International travel should be at a level to allow for adequate oversight of field activities, provide direction to technical staff and management of support staff in the home office. A minimum of 25% international travel is suggested.

Non-key Staff: The proposed staff should demonstrate the applicant's ability to design, implement, monitor and evaluate the activities of the Cooperative Agreement across the specific technical areas related to USAID GH's strategic objectives, Bureau-wide cross-cutting and Field technical priorities. Following are illustrative areas of expertise that should be provided by the staff of the Recipient:

• Reproductive health & family planning • Maternal health • Neonatal and child health • Nutrition • Infectious diseases (primarily TB and malaria) • HIV/AIDS/STIs • Health system performance • Economics and health financing	• Complex emergencies • Gender • Adolescent health • Epidemiology • Capacity building of institutions and individuals • Information technology • Routine health information systems • Statistical analysis • Information diffusion

Additional technical areas may be included as new technical priorities emerge during the life of the Agreement.

- **Management staff:** The management staff must include, at a minimum, a senior administrative officer with at least 5 years experience working with a large (>10 million dollars/annum) USAID agreement or contract.
- **Technical staff**: The technical staff should collectively have the knowledge and skills to provide leadership and technical guidance to a wide range of clients in the technical areas listed above. The technical staff will have educational background as appropriate for the positions proposed. There will be an adequate proportion of the staff with extensive experience working in monitoring and evaluation of PHN programs in developing countries. It is expected that a balance of senior and junior technical staff will be included, including staff of a technical level to provide leadership in the collaboration with host-country partners at all levels as well as collaboration with international donor agencies. Staff will have fluency in English, French, Spanish, Arabic, Russian and Portuguese. International travel will be required.
- **Support staff**: The broad range of activities and achievements called for across Results 1-6 demand a highly capable and high performing support staff.

[Applicants should: 1) provide a full staffing plan, including support staff, with underlying rationale, including an organigram demonstrating lines of authority and staff responsibility accompanied by position descriptions for each position proposed; 2) if being proposed, provide the rationale for the use of consultants and/or locally-hired, long-term resident advisors; 3) propose and justify the configuration of proposed key staff positions in addition to or in substitution of those proposed above; 4) provide a matrix of all personnel and the relevant skills

they bring to the performance of this Program Description. Resumes for all staff, and letters of commitment from key staff should be included in an annex.]

APPLICATION FORMAT

A. Preparation Guidelines

All applications received by the deadline will be reviewed for responsiveness to the specifications outlined in these guidelines and the application format. Section II addresses the technical evaluation procedures for the applications. Applications that are submitted late or are incomplete run the risk of not being considered in the review process.

Applications will be submitted in two separate parts: (a) technical and (b) cost (financial management and financial plan). Technical portions of applications should be submitted in an original and six (6) copies and cost portions of applications in an original and two (2) copies.

The application will be prepared according to the structural format set forth below. Applications must be submitted to the location indicated in the cover letter accompanying this RFA by the date and time specified.

Technical applications will be concise, specific and complete. The application will demonstrate the applicant's capabilities and expertise with respect to achieving the activity objective and the intermediate results of the MEASURE Phase II program in the area of monitoring and evaluating (M&E) population, health and nutrition programs, generating demand for M&E data, facilitating use of M&E data and building M&E capacity. Strategies and approaches identified will logically and explicitly reflect the MEASURE Phase II guiding principles described in this RFA. The application will also clearly and rationally propose approaches most likely to have the greatest impact on principal beneficiaries, as well as strategies for coordination with the major partners identified below. The application will take into account the technical evaluation criteria found in Section II.

Applicants will retain for their records one copy of the application and all enclosures that accompany the application. Erasures or other changes must be initialed by the person signing the application. USAID will consider only applications conforming to the format prescribed below so as to facilitate the competitive review of the applications.

B. Technical Application Format

USAID requests that applications be kept as concise and specific as possible. The technical portion of the application shall be no more than 75 pages, excluding attachments. Detailed information should be presented only when required by specific RFA instructions. Applications shall be on pages of 8-1/2 inch by 11-inch paper (210 mm by 297-mm paper), single-spaced, 10 pitch or larger type in a single column, with one-inch margins on all sides. At minimum, attachments should include one for the key personnel resumés and one for an organizational capability and past performance. Applicants shall provide the names of the individuals responsible for the preparation of

the application. USAID requires that applications provide all information requested as per the general format described later in this section.

The technical and cost evaluation criteria, with the possible points allocated to each, are described below. The maximum number of points available is XXX.

The following section compiles the application instructions that are found throughout the Program Description.

Result 1:
Applicants should describe the strategic approach they would use to address the issue of increasing demand for quality data, information, methods and tools, including but not limited to strategies and illustrative activities for the following: identifying users and potential users of data/information and for assessing their unmet data/information needs; determining the constraints to data use among potential target audiences and data user groups; and coordinating with other partners in these demand building efforts. This strategic approach should be based on a sound, well-articulated rationale.

Result 2:
Applicants should outline a comprehensive, strategic M&E capacity building plan that addresses the issues that are identified above, including, but not limited to: specific skill areas to be addressed through M&E capacity building; target groups and beneficiaries for capacity building efforts; differing needs for capacity-building across the GH Bureau's five health SOs; trainee follow-up; short-term and long-term capacity building approaches; strategies for introducing, disseminating and encouraging use of new and existing tools and methods; coordination and collaboration in capacity building efforts with partners; and resource diversification, cost recovery and sustainability.

Result 3:
Applicants should outline strategies and illustrative activities for ensuring field-level and international collaboration and coordination with various relevant partners. In particular, the application should discuss what staff positions, structures and systems will be put into place to promote field and international coordination and collaboration in monitoring and evaluation research, technical assistance, planning and capacity building. In addition, Applicants should identify CAs, NGOs and PVOs, and global projects with overlapping mandates in M&E, data use, and communication and dissemination, and accordingly provide strategies and illustrative activities for optimizing collaboration and coordination with these partners and projects.

Result 4:
Applicants should present a draft research and development agenda that covers the full range of the PHN sector and highlights what they see as the key areas of pursuit for the Cooperative Agreement as part of MEASURE Phase II. As part of this plan, Applicants should indicate: what criteria would be used for selection of new research and tool development topics, how the research and development agenda under the cooperative

agreement complements other worldwide efforts, how they would partner with other groups in R&D efforts, and how capacity building will be incorporated into the work that focuses on this result.

Results 5 and 6

Applicants should choose a topic of emerging interest and prepare an illustrative data dissemination plan that focuses on enhancing the availability of data collected by this Agreement that are relevant to the topic.

Applicants should present a strategy for data "translation" and facilitation of data use that reflects their expertise in state-of-the-art techniques as well as current technologies. This strategy should describe the approach for identifying and reaching target audiences, the methods and approaches used to facilitate data, information and tool use, the partners involved in the facilitation activity according to target audience and end user and the types of activities that will be developed to address constraints. The strategy should also discuss how the applicant will monitor progress towards increasing use of data in program planning, management, and policy making. Applicants should also discuss how they will encourage USAID missions and other partners to value and support these data, information and tool "translation" and use activities.

Country strategies:

Applicants should provide a sample country strategy, including illustrative indicators, for one of the countries listed above that covers the elements described above. In particular, applicants should include a comprehensive data collection plan, a data dissemination, translation and use plan, and a capacity building plan, as well as a description of the process that would be used to develop such strategies and the project's internal review process for country strategies and activity products. Applicants should also describe how the evaluation criteria will be developed and monitored for each country strategy.

Use of core funds:

Applicants should present an illustrative strategy for the use of core funds. For application purposes, applicants should assume they will receive core funds from all five GH SOs in the following proportions: $xx SO1; $ss SO2; $xx SO3; $xx SO4; and $xx SO5. The strategy should propose activities that would be relevant across all SOs and illustrative SO-specific activities.

M&E:

Applicants should lay out a strategic framework for the six Results under the MEASURE Phase II Activity Objective that demonstrates the contribution that the Cooperative Agreement is expected to make to each Result. In addition, Applicants should explain how they would define the relationship and contribution of their work to the strategic frameworks of Missions in countries where they are working and USAID/ Washington GH strategic framework. At a minimum applicants should identify: Intermediate Results that would lead to their contribution toward achieving each of the six Results; illustrative activities that would lead to accomplishing Results and Intermediate Results and an indication of what would determine selection of the activities; indicators that

would be used to monitor progress; and a detailed plan for how indicators will be tracked on an ongoing basis that will facilitate Results Reporting to USAID Washington and USAID Missions. Finally, Applicants should identify how they might collaborate with other MEASURE Phase II partners in efforts to monitor the progress of MEASURE Phase II overall.

Management:
Applicants should outline their strategy for addressing key management challenges including but not limited to: internal and external coordination and communication, establishing lines of authority, financial management and decision making, and managing to ensure the achievement of the new and challenging demand and facilitation results.

Staffing:
Applicants should: 1) provide a full staffing plan, including support staff, with underlying rationale, including an organigram demonstrating lines of authority and staff responsibility accompanied by position descriptions for each position proposed; 2) if being proposed, provide the rationale for the use of consultants and/or locally-hired, long-term resident advisors; 3) propose and justify the configuration of proposed key staff positions in addition to or in substitution of those proposed above; 4) provide a matrix of all personnel and the relevant skills they bring to the performance of this Program Description. Resumes for all staff, and letters of commitment from key staff should be included in an annex.

M. EVALUATION CRITERIA

M.1 Technical Understanding and Approach **Total: 80 points**

General quality and responsiveness of proposal and technical approach

Demonstrated understanding of the unique contribution that the Cooperative Agreement will make to the MEASURE Phase II Activity Objective and each MEASURE Phase II Results, and the technical and creative merit of proposed intermediate results, illustrative activities, indicators and evaluation plan.
15 points

Technical and creative merit of overall plan for achieving IRs 1-6:

a) Technical and creative merit of strategic approach for increasing the demand for quality information, and also the demand for the tools. **10 points**

b) Technical and creative merit of proposed M&E capacity-building plan. **10 points**

c) Technical and creative merit of proposed strategies and activities for ensuring collaboration and coordination at multiple levels with relevant partners, including other MEASURE Phase II CAs. **5 points**

d) Technical and creative merit of proposed research and development agenda, including attention to diverse R&D needs within the health sector . **10 points**

e) Technical and creative merit of strategy for data "translation" and facilitation of data use, reflecting use if state-of-the-art techniques and current technologies; participation of appropriate partners; monitoring progress toward increasing data use **15 points**

Demonstrated understanding of country activities as evidenced in the sample country strategy. **5 points**

Technical merit of proposed core-funded activities, including both cross-SO and SO specific work. **5 points**

Technical and creative merit of approach for integrating gender into M&E activities, including gender-specific dissemination and capacity-building strategies. **5 points**

M.2 Qualifications of Proposed Personnel **Total: 40 points**

Leadership ability and technical skills and creativity of the proposed Project Director and Deputy or other proposed alternative key staff appropriate to guiding the work of this Cooperative Agreement. **10 points**

Expertise of Senior Technical Specialist: Demand and Data Use or proposed alternative key staff in directing, managing, implementing, and evaluating large, complex projects involving generating demand for, making available, and building capacity to use high quality M&E data for program management and policy formulation. **5 points**

Sound expertise among project staff to cover the full range of technical, field and administrative skills required for successful implementation of this program. **20 points**

Successful experience among key staff in addressing gender issues in the M&E arena, including the areas of data collection, analysis, capacity-building, and translation. **5 points**

M.3Management **Total: 20 points**

Clear, logical and appropriate lines of authority in the plan for managing all project staff including subrecipients.
8 points

Overall efficiency of management plan for accomplishing all aspects of project implementation (i.e., core and field supported), especially achievement of the demand, translation and facilitation of use results. **6 points**

Merit and feasibility of plan for coordinating with other MEASURE Phase II partners and other CAs. **3 points**

Clear plan for how information from the monitoring and evaluation system will be used to monitor and manage the program. **3 points**

M.4 Institutional Capacity and Past Performance **Total: 20 points**

Institutional Capability to Produce Results

(a) The Government will evaluate the quality of the applicant's past performance. This evaluation is separate and distinct from the Agreement Officer's responsibility determination. The assessment of the applicant's past performance will be used to evaluate the relative capability of the applicant and other competitors to successfully meet the requirements of the RFA. Past performance of significant and/or critical subrecipient will be considered to the extent warranted by the subrecipient's involvement in the proposed effort.

(b) The Government reserves the right to obtain information for use in the evaluation of past performance from any and all sources outside of the Government. Applicant lacking relevant past performance history will receive a neutral rating for past performance. However, the proposal of an applicant with no relevant past performance history, while rate neutral in past performance, may not represent the most advantageous proposal to the Government and thus, may be an unsuccessful proposal when compared to the proposals of other applicant. The offer must provide the information requested above for past performance evaluation or affirmatively state that it possesses no relevant directly related or similar past performance experience. The Government reserves the right not to evaluate or consider for award the entire proposal from an applicant which fails to provide the past performance information or which fails to assert that it has no relevant directly related or similar past performance experience.

Demonstrated ability to produce results that contribute to USAID mission and GH strategic objectives, particularly in collaboration with other CAs. **7 points**

Successful history of working collaboratively with varied public and private institutions that include GH CAs, PVOs, NGOs, policy makers, media, advocacy groups, other bilateral and multilateral donors, GH and other USAID regional and technical bureaus. **7 points**

Demonstrated successful history of good organizational and management practices. **6 points**